BRIDGEPORT
FAMILY VISION CLINIC

Records Request/Release

Patient Name:_____ DOB:_____

Guardian or Authorized Party Name (if applicable):_____

I authorize the use and disclosure of my health information as described below:

Information Requested:

- ❑ Records relating to treatment dates from:_____ to_____
- ❑ Records for all care at this facility or by this doctor
- ❑ Other (Please specify) _____

I understand that I have the right to revoke this authorization, in writing, at any time, except (1) where uses or disclosures have already been made based upon my original permission or (2) the authorization was obtained as a condition of securing insurance coverage and the insurer by law has the right to contest a claim or the insurance policy. I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, and/or treatment.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and no longer protected by the Federal Privacy Standards.

Information to be Released: [ ] from [ ] to _____
_____
_____

[ ] from [ ] to

Bridgeport Family Vision Clinic
9101 Bridgeport Way SW, Suite C
Lakewood, WA 98499
(253) 584-2020
(253) 588-0545 fax

_____ _____
Signature of Patient or Guardian Date

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient_____ Print Name_____

Signature_____